IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

ISAAC ISAIAH, M.D.	*	
Plaintiff,	*	
	*	
v.	*	Civil No. JFM 07–2197
	*	
WHMS BRADDOCK HOSPITAL	*	
CORPORATION & THE MEMORIAL	*	
HOSPITAL AND MEDICAL CENTER	*	
OF CUMBERLAND INCORPORATED	*	
Defendants.	*	
	*	

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MEMORANDUM

Plaintiff Dr. Isaac Isaiah ("Dr. Isaiah") has filed suit against defendants WMHS Braddock Hospital Corporation and The Memorial Hospital and Medical Center of Cumberland, Inc. (collectively "defendants"). Plaintiff has asserted four claims against defendants: (1) breach of contract (Am. Compl. ¶¶ 35–42); (2) defamation (*id.* ¶¶ 43–50); (3) tortious interference with prospective advantage (*id.* ¶¶ 51–54); and (4) false light invasion of privacy (*id.* ¶¶ 55–56). These claims arise out of defendants' decision to suspend and then revoke plaintiff's privileges at their hospitals. Plaintiff and defendants have both filed motions for summary judgment. For the reasons presented below, I will deny plaintiff's motion and grant defendants' motions.

FACTS

Because the legal issues in this case are highly fact intensive, I provide here a detailed summary of the factual history giving rise to this litigation. Dr. Isaiah is a licensed medical doctor and certified surgeon. (*Id.* ¶ 6.) From 1992–2000, he worked as a surgeon at the Lincoln Medical Center in North Carolina. (Defs.' Ex. 1 at 2.) His application for privileges at Gaston Memorial Hospital, also in North Carolina, was denied in 1999 as a result of the low number of

surgical procedures that he had performed.[1] (Defs.' Ex. 2 at 2.) Also in 1999, Dr. Isaiah applied for privileges at defendants' hospitals in Cumberland, Maryland. (Am. Compl. ¶ 7.) He was granted provisional privileges at both hospitals in 2000 (*id.*), although the privileges were conditioned upon the completion of a proctoring program in light of several "red flags" that the Chair of the Department of Surgery at Memorial Hospital[2] saw in Dr. Isaiah's record (Defs.' Ex. 3 at 1; *see also* Defs.' Ex. 4; Pl.'s Ex. C).

During this proctoring period, a number of concerns were raised about Dr. Isaiah's abilities; in particular, an e-mail was circulated discussing his performance during several surgeries (Defs.' Ex. 5), and the Vice President of Medical Affairs, Dr. Raver, wrote an internal memorandum discussing a variety of his peers' concerns about Dr. Isaiah (Defs.' Ex. 7). These concerns included Dr. Isaiah's length of operations, surgical judgment, decisionmaking, ability to identify anatomy, and case selection. (*Id.*) Despite these concerns, Dr. Isaiah eventually completed the proctoring program and, in 2001, was granted full privileges at the hospitals. (Defs.' Ex. 8; Pl.'s Ex. C at 4.)

On April 7, 2004, Dr. Isaiah was scheduled to perform a gallbladder removal surgery on a 25 year old patient with acute gallbladder disease. (Am. Compl. ¶ 12.) He initially planned to perform the surgery with a laparoscope.[3] (*Id.*) In advance of the surgery, however, Dr. Isaiah

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[1] According to the record, privileges were not denied to Dr. Isaiah because of his "competency . . . [as a] surgeon." (Defs.' Ex. 2 at 2.)

[2] There are two separate defendant-hospitals, although they appear to operate largely as one entity for purposes of this case. Although there are separate Boards of Trustee and separate Chairs of the Departments of Surgery, I often refer to the defendants as one entity, reflective of the reality of the situation.

[3] Laparoscopic surgery "is a modern surgical technique in which abdominal operations are performed through small incisions and the use of a telescopic rod lens systems connected to a video camera." (Defs.' Mem. in Supp. of Mot. for Summ. J. at 5 n.3.)

warned the patient that due to the patient's "acute illness and his obesity," a traditional open procedure requiring larger incisions into the abdomen may become necessary. (*Id.*) While the surgery was in progress, Dr. Isaiah did in fact conclude that an open procedure was the safer course, and made the decision to convert to such a procedure. (*Id.* ¶ 13.) When he informed the attending anesthesiologist, Dr. Hodges, of his decision to perform an open procedure, the anesthesiologist insisted that Dr. Isaiah stop the surgery and acquire a second opinion from another surgeon. (*Id.*) Another surgeon, Dr. Schroeder, was located and brought into the operating room. (*Id.* ¶ 14.) Dr. Schroeder did not make any "attempt to dissuade [Dr. Isaiah] from converting the procedure from a laparoscopic to an open procedure." (*Id.*)

The surgery took four hours and three minutes. (Defs.' Ex. 9.) Dr. Hodges later testified that "this is far longer than the norm" for such a surgery, and that the surgery's extended length gave him pause. (Defs.' Ex. 6 at 479:8–9.) Dr. Hodges was also concerned about the amount of blood lost by the patient during the surgery. (*Id.* at 486:15–17 ("In my personal experience this amount of blood loss is quite unusual for this particular surgery.").) There is some dispute about the amount of blood that the patient actually lost during the surgery: Dr. Isaiah initially noted a blood loss of 800ccs (Defs.' Ex. 15 at 2), later amended the blood loss amount to 300–400ccs (*id.*), and Dr. Hodges noted a blood loss of 1,300ccs (Defs.' Ex. 9). It is undisputed that the patient made a full recovery.

Following the surgery, Dr. Hodges approached Dr. Isaiah in order to discuss his concerns about the gallbladder operation. (*See* Defs.' Ex. 12 at 495–96.) Dr. Hodges subsequently contacted Dr. Raver, the Vice President of Medical Affairs, at approximately 9:30p.m. on the

night of the surgery.[4] (Defs.' Ex. 10). According to Dr. Raver's notes about this conversation, Dr. Hodges was "quite concerned about a patient who had surgery with Dr. Isaiah." (*Id.* at 1.) In particular, Dr. Hodges was worried about Dr. Isaiah's surgical abilities:

> Dr. Hodges reported . . . that he was concerned, as Dr. Isaiah did not seem to have adequate manual dexterity or seem to recognize the anatomic landmarks. He apparently struggled through some time not sure what he was visualizing via the laparoscope. The staff prevailed upon Dr. Schroeder to come in to [sic] the room. Dr. Hodges reported that Dr. Schroeder did not agree that findings as described by Dr. Isaiah via the laparoscope were necessarily the case . . . . The operative note reports that there was 300 to 400 cc's of blood loss. The anesthesia note reports that there was an estimated blood loss of 1300ccs.

(*Id.* at 1–2.)

In light of the concerns expressed by Dr. Hodges, a longstanding member of the hospital staff who rarely complained and someone that Dr. Raver greatly respected, Dr. Raver spoke to Dr. Schroeder about the operation. (*See* Defs.' Ex. 6 at 55:15–22 (noting that Dr. Hodges worked for defendants for "30 years off and on" and that Dr. Raver believed him to be an "extremely high-quality physician who has been extremely ethical and extremely competent and well-read. . . . And he is a person who has not and does not complain really about anyone unless he is greatly concerned"); *see also* Defs.' Ex. 12 (notes from Dr. Raver's meeting with Dr. Schroeder).) As Dr. Raver recorded that conversation, Dr. Schroeder "acknowledge[d] that [the surgery] was a difficult case but that [an] experienced surgeon *should [have been] able to identify the landmarks and dissect th[e] area with little or no difficulty and that [Dr. Isaiah's] inability to do so was 'wrong.'* (*Id.* (emphasis added).) Moreover, Dr. Schroeder "felt that Dr. Isaiah's technique and surgical skills are *not adequate* to be safely operating in this

[4] Additionally, Dr. Isaiah at some point spoke to Dr. Raver and objected to Dr. Hodges' alleged interference and blood loss calculation. (*See* Pl.'s Mem. in Supp. of Mot. for Summ. J. at 6.)

environment." (*Id.* (emphasis addded).)

Following his conversations with Dr. Hodges and Dr. Schroeder, Dr. Raver continued to investigate the gallbladder surgery. In particular, he met with the operating room staff and discussed the surgery. (Defs.' Ex. 10.) He also discussed the situation with the Chairmen of the Departments of Surgery of the two hospitals, the President of the Medical Staff, and defendants' President and CEO. (Defs.' Ex. 6 at 55–57.) In particular, Dr. Raver discussed the following with those persons:

> That this case was a culmination of multiple cases where the issues were similar, related to difficulty identifying laparoscopic procedures, identifying landmarks and being able to perform the procedure which, whether cause and effect or not, was at least marked by long surgical times. Appearing to struggle in the operating room to observers who in some cases had felt that they had to call for help. Failing to call for help himself or recognize that there was a problem and having higher blood loss as a result.

(*Id.* at 57.)

Following these discussions, Dr. Isaiah's privileges were summarily suspended on April 9, 2004, pursuant to letters signed by Dr. Raver as well as the President of the Medical Staff and the Chairmen of the Departments of Surgery of the two Hospitals. (Defs.' Ex. 13.)

The letters stated that the suspension was justified by provisions in the hospital bylaws that provided for precautionary suspensions when: "the activities or professional conduct of any Medical Staff Appointee are considered to be a departure from the standard of the Medical Staff or the Hospital"; "whenever a staff appointee is inconsistent with the efficient delivery of patient care at the generally recognized professional level of quality"; and "whenever a staff appointee's conduct shows the substantial likelihood of immediate injury or is detrimental to the health or [sic] any patient, employee or other person present in the Hospital." (Defs.' Ex. 13 (quoting Hospital Bylaws Article 10.4.5).)

Also on April 9, Dr. Raver met with Dr. Isaiah to inform him of the suspension, explain the reasoning and concerns behind the suspension, and discuss the hearing and review procedures that the Hospitals would employ. (*See* Defs.' Ex. 14.) During this meeting, Dr. Isaiah disputed the extent of the blood loss noted by Dr. Hodges and the operating room staff. (*Id.* at 1.) The meeting ended with Dr. Raver explaining to Dr. Isaiah that the Medical Events Subcommittee would meet in the next week to review the precautionary suspension. (*Id.* at 2.)

Several days after the surgery, on April 12, 2004, Dr. Hodges wrote a report that recorded his recollections about the operation and his "concerns regarding Dr. Isaiah's competence as a surgeon." (Defs.' Ex. 11 at 1.) Because of the importance that the defendants placed on Dr. Hodges' first-hand observation of the surgery in question, I will quote extensively from that document here:

> Once the laparoscope was inserted, it soon became evident that Dr. Isaiah was experiencing difficulty in obtaining adequate exposure of the gallbladder. More bleeding than we usually see at this point was observed. It was not long before Dr. Isaiah indicated that he probably would have to convert to an open procedure. I suggested consultation with another surgeon in an effort to spare the patient from an unnecessary open procedure if this was considered reasonable with some modification of exposure, etc. Dr. Isaiah readily agreed. Dr. Schroeder was just finishing a case and agreed to offer his opinion. After arriving in the room, Dr. Schroeder promptly commented that the visualization of his gallbladder was very inadequate, recommending additional suctioning to clear the blood which had accumulated and the insertion of an additional retractor through a [sic] one of the ports to improve exposure. Visualization promptly improved by at least 50%. There was some disagreement between the two surgeons as to the likely location of certain key structures . . . . One of the scrub nurses involved in this case told me later that, with the abdomen open, she clearly heard Dr. Isaiah state on more than one occasion. I don't know where I am.' . . . No one in the O.R. or the Anesthesia Department feels comfortable working with him, and it is not a personality issue. We are simply afraid that he is going to hurt someone at some point, and we do not want to be part of it.

(*Id.* at 1–2.)

On April 15, 2004, the Medical Events Subcommittee convened, met with Dr. Isaiah, and

discussed the precautionary suspension. (Defs.' Ex. 15.) According to the minutes of the Subcommittee meeting, information "from the most recent incident" was considered, as was "other pertinent data" and "complaints dat[ing] back to 2000 . . . ." (*Id.* at 2.) In particular, the Subcommittee was presented with evidence of the gallbladder removal operation and concomitant blood loss, length of surgery, and Dr. Isaiah's apparent statement, "I don't know where I am." (*Id.*) Additionally, the Subcommittee considered past surgeries and complaints; these included general concerns like lengthy operation times and inability to identify anatomy but also specific instances of allegedly problematic operations. (*Id.* at 2–8.) After reviewing the information, the Subcommittee identified "five major issues." (*Id.* at 3.) Those issues were: Dr. Isaiah's surgical competency, his clinical decision-making, his ethics and integrity, his obsessive-compulsive behavior, and his alleged examination of a patient's male genitals without consent during recovery from anesthesia. (*Id.*)

Dr. Isaiah was also provided the opportunity to defend and explain himself at this meeting. (*Id.* at 3–8.) The Subcommittee reached the conclusion "that [Dr. Isaiah's] surgical competence and clinical decision-making is *below the standards* of the hospital or other surgical staff." (*Id.* at 8 (emphasis added).) The Subcommittee was also concerned that Dr. Isaiah "denies he has any problems" (*id.*), and found troubling discrepancies between "operating room personnel documentation and what [Dr. Isaiah] himself reports" (*id.* at 9). Moreover, the Subcommittee noted that "anesthesia and operating room personnel are reluctant and uncomfortable working with [Dr. Isaiah] due to his lack of proficiency." (*Id.*) Ultimately, the Subcommittee voted unanimously to recommend a continuation of the suspension and that Dr. Isaiah's clinical privileges be revoked. (*Id.* at 8.)

On April 22, 2004, the Medical Executive Committee met to consider the Subcommittee's recommendations.[5] (Defs.' Ex. 16.) The Medical Executive Committee, "[a]fter a thorough review of the information, . . . agreed to accept the [Subcommittee's recommendation] that the precautionary suspension for [Dr. Isaiah] be continued and to recommend to the Board that all privileges be revoked." (*Id.* at 1–2.)

Next, defendants' Board of Trustees met to consider Dr. Isaiah's suspension. (*See* Defs.' Ex. 17.) On April 26, 2004, the Board convened, and the procedural and factual background of the suspension was presented to the Board by defendants' legal counsel, the President of the Medical Staff, and Dr. Raver. (*Id.* at 1.) According to the meeting's minutes, defendants' legal counsel "encouraged Board members to ask questions, to attempt to find out all of the facts, and to make a decision based on the best interests of patient care." (*Id.*) Additionally, Dr. Raver identified six areas of concern about Dr. Isaiah: longer than average surgical times; scheduling of surgeries that were not called for by medical necessity; discrepancies between Dr. Isaiah's reports and the reports of operating room personnel; problems with the treatment of pediatric patients; potentially inappropriate or unusual behavior including obsessive-compulsive behaviors and extended involuntary genital examinations; and issues of surgical skill and judgment, including problems identifying anatomy and flawed case selection. (*Id.* at 2.)

Moreover, the details of several specific cases were presented to the Board. (*Id.*; *see also* Defs.' Ex. 19, (document summarizing concerns about Dr. Isaiah's performance that was

[5] Defendants write that the Medical Executive Committee met "immediately following the Subcommittee meeting . . . ." (Defs.' Mem. in Supp. of Mot. for Summ. J. at 9.) The defendants' own exhibits, however, indicate that the meeting took place a week after the Subcommittee meeting. (*Compare* Defs.' Ex. 15 (indicating that Subcommittee met on April 15, 2004) *with* Defs.' Ex. 16 (indicating that Medical Executive Committee met on April 22, 2004).) This factual disparity is of no consequence to the outcome of the pending motions.

prepared by Dr. Raver for the Board's review).) The full patient charts for the cases that were discussed were made available for review at the Board meeting. (Defs.' Ex. 17 at 2.) After the presentation, "[t]here were a number of questions and considerable discussion." (*Id.*) An anesthesiologist who was present at the meeting "stated that the anesthesia staff is very uneasy when [Dr. Isaiah] is assigned to a surgical case, and they are watchful and attempt to pull in others to assist when there are problems." (*Id.* at 3.) The Board voted unanimously to accept the recommendation of the Medical Events Subcommittee and Medical Executive Committee to continue the precautionary suspension and take the necessary steps to revoke Dr. Isaiah's clinical privileges. (*Id.*)

On May 12, 2004, Dr. Isaiah was informed of the Board's decision, as well as the grounds for that decision.[6] (Defs.' Ex. 18; Defs.' Ex. 19.) He was also informed that he was "entitled to a hearing" and instructed on what steps he should take to request a hearing. (Defs.' Ex. 18 at 1–2.) Dr. Isaiah did request a hearing, and received a letter on August 2, 2004 that informed him of the date and time of the hearing, the nature of the hearing, his right to be represented by an attorney at the hearing, his right to call, examine, and cross-examine witnesses, his right to introduce evidence, and his right to submit a memorandum in support of his position. (Defs.' Ex. 20 at 1.) The letter also listed the issues underlying the suspension that

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[6] The letter informing Dr. Isaiah of the Board's decision stated that the Board relied on a variety of grounds in upholding the suspension:

> The reasons for the decisions . . . were that [the Board] concluded that the information presented showed professional conduct considered to be a departure from the standards of the Medical Staff and Hospital, and conduct inconsistent with recognized professional levels of quality in regard to excessive surgery time, excessive blood loss, lack of anatomical knowledge, lack of sufficient surgical skill, failure to provide full and accurate surgical reports, lack of proficiency with surgical instruments and techniques, inappropriate surgical judgments, lack of sufficient current surgical experience and proficiency and inappropriate medical judgments. The Board further concluded that there was a substantial likelihood of injury or detriment to the health or safety of patients.

(Defs.' Ex. 18 at 1.)

would be discussed at the hearing. (*Id.* at 2.) Finally, the letter told Dr. Isaiah what evidence, including what patient records and histories, the defendants would rely on at the hearing. (*Id.* at 2–3.)

The hearing took place on February 16 and 17, March 22 and 23, and July 12, 2005, and was presided over by an attorney. (Defs.' Mem. at 10.) A variety of evidence was presented at the hearing, some of which favored Dr. Isaiah, and some of which was highly critical of his performance. Dr. Isaiah presented several witnesses, including three surgeons, two of whom knew Dr. Isaiah and had worked with him in earlier years. (*See* Pl.'s Ex. D; Pl.'s Ex. E; Pl.'s Ex. F.) Defendants also put forth evidence, including a report from a surgeon and a second report from the same surgeon that analyzed and criticized the methodologies of the plaintiff's witnesses. (Defs.' Reply Ex. 3.) That same surgeon also testified at the hearing, and made clear his opinion that Dr. Isaiah did not have "adequate current surgical skills and judgment to comply with accepted standards of care in general surgery[.]" (Defs.' Ex. 6 at 923:1–12 ("Q: . . . Have you formed an opinion as to whether . . . Dr. Isaiah, has adequate current surgical skill and judgment to comply with accepted standards of care in general surgery? . . . . A: He does not.").)

In November 2005, the Hearing Panel issued its findings and recommendations. (Defs.' Ex. 21.) First, the Panel set out five factual findings that were adverse to Dr. Isaiah; those findings were: (1) a failure to make complete and accurate records, which violated the standard of care; (2) the performance of two post-operative genital exams without consent and "without any apparent medical purpose," which violated medical ethics; (3) discrepancies between records; (4) excessive blood loss, low number of surgeries, long operation times, and a refusal to seek help or accept recommendations and; (5) that there was no conspiracy to destroy his career,

as asserted by Dr. Isaiah. (Defs.' Ex. 21 at 1.) In light of these findings, the Panel "recommended that the precautionary suspension of Dr. Isaac Isaiah's clinical and surgical privileges be continued." (*Id.* at 1–2.)

Dr. Isaiah appealed this decision, and the Appellate Review Body heard oral argument and considered the evidence and memoranda of both sides. (Defs.' Ex. 22 at 1.) Noting that twelve surgeons and fifteen other doctors had participated in the review process (*id.* at 2), the Appellate Review Body unanimously upheld the decision of the Hearing Panel on May 15, 2006 (*id.* at 1). Following the decision of the Appellate Review Body, defendants' Board of Trustees held a meeting to review the evidence and procedures and discuss whether Dr. Isaiah's suspension should be made permanent. (Defs.' Reply Ex. 2) The Board unanimously voted to uphold the final suspension and revocation of Dr. Isaiah's privileges on December 11, 2006. (*See id.* at 10–14.) Dr. Isaiah was informed of this decision by letter dated December 20, 2006. (Defs.' Reply Ex. 4.)

As required by law, defendants reported the suspension and revocation to the National Practitioner's Data Bank.[7] (Am. Compl. ¶ 34; Pl.'s Ex. A.) The report stated that the grounds for the suspension and revocation "included the extent of blood loss and length of a gall bladder procedure; physician personality traits of stubbornness, compulsiveness, unwillingness to accept suggestions and denial; inaccurate reporting on surgical records; excessive surgical times; and observations of apparent difficulty during laparoscopic procedures." (*Id.* at 2.) The basis for the

[7] "The National Practitioner's Data Bank is an organization created under the [Heath Care Quality Improvement Act] to collect information on physicians, including reports of adverse peer review actions. 'Each health care entity must report to the Board of Medical Examiners . . . [a]ny professional review action that adversely affects the clinical privileges of a physician.' The Board of Medical Examiners must in turn report this information to the National Practitioner Data Bank." *Brown v. Presbyterian Healthcare Servs.*, 101 F.3d 1324, 1328 n.3 (10th Cir. 1996) (quoting 45 C.F.R. § 60.9(a)) (internal citations omitted).

suspension and revocation was summarized as "substandard or inadequate skill level." (*Id.*) Plaintiff alleges that this reporting had and continues to have a "substantial [negative] impact on plaintiff's ability to practice medicine and his ability to earn income from the practice of medicine." (Am. Compl. ¶ 34.)

Dr. Isaiah subsequently filed this suit against defendants, alleging breach of contract, defamation, false light invasion of privacy, and tortious inference with prospective advantage. (*See generally id.*)

ANALYSIS

Defendants have moved for summary judgment on the grounds that they are entitled to immunity under the Health Care Quality Improvement Act, 42 U.S.C. § 11111 *et seq.*, and under Maryland state immunity statutes. Defendants also argue that plaintiff has failed to make out a *prima facie* claim for defamation, tortious interference with prospective advantage, and false light invasion of privacy. Plaintiff has moved for summary judgment as well, contending that there are no genuine issues of material fact with respect to defendants' liability on both the contract and tort claims.

I. Legal Standard

Summary judgment will be granted when there are no genuine issues of material fact and the moving party can demonstrate that it is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). A material fact is one that may affect the outcome of a suit. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). At this stage, all facts will be construed in the light most favorable to, and all justifiable inferences will be drawn in favor of, the non-moving party. *See Matsushita Elec. Indus. Co. Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986).

In part, the pending motions dispute the applicability of federal immunity under the Health Care Quality Improvement Act. Because of particular statutory language in that Act, an unconventional summary judgment standard partially governs this case. *See* 42 U.S.C. § 11112(a) ("A professional review action shall be presumed to have met the preceding standards necessary for [immunity] unless the presumption is rebutted by a preponderance of the evidence."); *see also Gabaldoni v. Washington County Hosp. Ass'n*, 250 F.3d 255, 260 (4th Cir. 2001) ("Due to the presumption of immunity contained in section 11112(a) [of the Act], we must apply an unconventional standard in determining whether [defendant] was entitled to summary judgment . . . ."). Hospitals, like defendants, are entitled to a presumption of immunity from civil damages actions such as the instant one, and the burden of rebutting that presumption rests on the shoulders of the plaintiff.[8] *See, e.g., Brader v. Alleghany Gen. Hosp.*, 167 F.3d 832, 839 (3d Cir. 1999) (" . . . [A]lthough the defendant is the moving party, we must examine the record to determine whether the plaintiff 'satisfied his burden of producing evidence that would allow a reasonable jury to conclude that the Hospital's peer review disciplinary process failed to meet the standards of [the Health Care Quality Improvement Act].'") (quoting *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1334 (11th Cir. 1994)). Thus, in a summary judgment posture, the question is "whether a reasonable jury, viewing all facts in a light most favorable to [plaintiff], could conclude that he had shown, by a preponderance of the evidence, that [defendant's] actions fell outside the scope of section 11112(a)." *Gabaldoni*, 250 F.3d at 260.

[8] Dr. Isaiah incorrectly states that the burden to establish immunity is on the defendants: "The Defendants, in order to obtain immunity under . . . the Health Care Quality Improvement Act, must show that [their] action against the Plaintiff was taken: . . . [listing immunity elements]." (Pl.'s Mem. in Supp. of Mot. for Summ. J. at 13.) Contrary to Dr. Isaiah's statement, the plaintiff has the burden of showing that defendants are not entitled to immunity.

II. Immunity Under The Health Care Quality Improvement Act

Because it is a threshold issue that may dispose of the entire case, I will address the immunity question first. "The Health Care Quality Improvement Act was enacted in 1986 to improve the quality of medical care by restricting the ability of physicians who have been found to be incompetent from repeating this malpractice by moving from state to state without discovery of such finding." *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1028 (4th Cir. 1994). To advance that goal, Congress created a presumption that hospitals would be immune from civil suits seeking damages for adverse employment actions against doctors that were taken as a result of peer review actions.

In particular, the Health Care Quality Improvement Act provides defendants with immunity from damages arising from professional review actions[9] if the actions were taken:

> (1) In the reasonable belief that the action was in furtherance of quality health care;
>
> (2) After a reasonable effort to obtain the facts of the matter;
>
> (3) After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and
>
> (4) In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

42 U.S.C. § 11112(a).

Dr. Isaiah argues that defendants are not entitled to immunity because he has presented sufficient evidence so that a jury could conclude, by a preponderance of the evidence, that

[9] Dr. Isaiah does not dispute that the decisions at issue were "professional review actions" that are entitled to presumptive immunity under 42 U.S.C. § 11111.

defendants failed to act appropriately with respect to all four prongs of the immunity analysis.[10] If the plaintiff carries his burden with respect to even one of the four prongs, the defendants are not entitled to immunity. *See, e.g.*, *Brown v. Presbyterian Healthcare Servs.*, 101 F.3d 1324, 1333 (10th Cir. 1996) ("[I]f a plaintiff challenging a peer review action proves, by a preponderance of the evidence, any one of the four requirements [for immunity] was not satisfied, the peer review body is no longer afforded immunity from damages under the [Health Care Quality Improvement Act].").

The Fourth Circuit has made clear that the standard for immunity under the Health Care Quality Improvement Act "is an objective one which looks to the totality of the circumstances." *Imperial*, 37 F.3d at 1030; *see also Goodwich v. Sinai Hosp. of Balt., Inc.*, 680 A.2d 1067, 1073 (Md. 1996) ("The legislative history of § 11112(a) reveals that Congress intended that the test of the statute's reasonableness requirements be an objective one, rather than a subjective good faith standard."). Thus, because the standard is an objective one, "the good or bad faith of the reviewers is irrelevant." *Brader*, 167 F.3d at 840; *see also Sugarbaker v. SSM Health Care*, 190 F.3d 905, 914 (8th Cir. 1999) ("In the [Health Care Quality Improvement Act] immunity context, the circuits that have considered the issue all agree that the subjective bias or bad faith motives of the peer reviewers is irrelevant.").

With this legal background in mind, and viewing all facts in the light most favorable to

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[10] In particular, Dr. Isaiah avers that defendants are not entitled to immunity because:

a. the action was not taken in the reasonable belief that the action was in furtherance of quality health care;
b. the action was not taken after a reasonable effort to obtain the facts of the matter;
c. the action was not taken after affording the plaintiff with adequate notice and a fair hearing;
d. the hearing panel failed to state that its decision was based on the reasonable belief that the plaintiff's conduct was an imminent danger to the health of any individual;
e. the defendant failed to state that its action was required to prevent the imminent danger to the health of any individual.

(Am. Compl. ¶ 34.)

the plaintiff, I examine each prong of the immunity requirements below.

A. Reasonable Belief That The Action Was In Furtherance Of Quality Health Care

Defendants contend that they suspended and eventually revoked Dr. Isaiah's privileges for a variety of reasons, but particularly because of repeated instances of surgical incompetence that put patients at risk. Defendants have submitted a plethora of evidence that supports this position, and that evidence has been incorporated into the facts section *supra*. Plaintiff disputes defendants' position, but fails to present contrary evidence that rebuts the presumption that defendants had a reasonable belief that their actions were in furtherance of quality health care. Indeed, much of plaintiff's complaint and memoranda consist of statements that are flatly contradicted by the unchallenged evidence.

This prong of the immunity inquiry does not require that the Court determine that Dr. Isaiah actually made a mistake, breached a standard of care, or put a patient in danger. To the contrary, all that is required is a finding that the defendants possessed a *reasonable belief* that the action taken would advance the goal of quality health care. Thus, an inaccurate but reasonable determination would still be entitled to immunity. *See Imperial*, 37 F.3d at 1030 ("But more importantly to the issue at hand, even if [the plaintiff] could show that these doctors reached an incorrect conclusion on a particular medical issue . . ., that does not meet the burden of contradicting the existence of a *reasonable belief* that they were furthering health care quality . . . .") (emphasis in original); *Goodwich*, 680 A.2d at 1080 (noting that the immunity analysis does not focus on "whether, in any given instance, there was a breach of the standard of care" or whether the defendant's conclusions were correct but rather "the relevant focus is whether the [committee] had enough evidence to make an objectively reasonable decision"); *Bender v.*

Suburban Hosp., Inc., 758 A.2d 1090, 1102 (Md. Ct. Spec. App. 2000) ("Objective reasonableness does not imply that the peer review committee's process is perfect or even correct in every respect.").

Because the burden is on the plaintiff here, I will begin by analyzing his arguments. Dr. Isaiah contends that defendants' decision was the result of a conspiracy to derail his career, undergirded by the compilation of a secret file of complaints against him. (*See, e.g.*, Pl.'s Reply at 6 (discussing alleged "witch hunt" against plaintiff).) There is no merit to this assertion. Dr. Isaiah has produced not a shred of evidence of a conspiracy, and certainly nothing sufficient to rebut the immunity presumption. Yet even if Dr. Isaiah had produced some evidence, the evidence produced by the defendants clearly demonstrates there was a reasonable belief that the suspension and revocation was in furtherance of quality health care. As the facts described above indicate, the precautionary suspension came about after Dr. Raver was contacted by a respected member of the hospital staff, Dr. Hodges. Dr. Hodges described his concerns with Dr. Isaiah's surgical skills, both with respect to the gallbladder removal surgery and more generally, and those concerns were echoed in Dr. Raver's interview with Dr. Schroeder, another surgeon. (Defs.' Ex. 12 (noting that Dr. Schroeder "felt that Dr. Isaiah's technique and surgical skills are *not adequate* to be safely operating in this environment") (emphasis added).) Finally, Dr. Raver spoke with operating room staff that gave even more weight to the concerns of the two doctors. (Defs.' Ex. 10.) Those conversations with the operating room staff also gave rise to other concerns, including the belief of the staff that "no other surgeons make large incisions or have difficulty with CO2 leaks" like Dr. Isaiah does. (*Id.*) Dr. Raver also took the time to speak with Dr. Isaiah. (*Id.*)

After gathering all of this information, the appropriate parties – to wit, Dr. Raver, the Chairmen of the Departments of Surgery, and the President of the Medical Staff – made the decision to suspend Dr. Isaiah. (Defs.' Ex. 13.) The letter informing Dr. Isaiah of the suspension clearly stated reasons related to the advancement of health care. (*Id.* (stating that the suspension was authorized by provisions in the Bylaws involving substandard performance, poor patient care, and threat of injury to patient well-being).) All of these facts, which include an allegation by a general surgeon that Dr. Isaiah was "not adequate to be safely operating in this environment" (Defs.' Ex. 12), are challenged by the plaintiff only with baseless speculation. Defendants clearly possessed sufficient evidence to believe that issuing a precautionary suspension to Dr. Isaiah would further quality health care, and the evidence presented here shows that the decision was based on a reasonable belief that it would advance quality health care.

The same is true of defendants' decision to upheld the suspension and ultimately to revoke Dr. Isaiah's privileges. Most of the bodies to review the suspension and recommend revocation stated reasons for their decision that were clearly related to the furtherance of health care. (*See* Defs.' Ex. 15 at 8 (report of Medical Events Subcommittee noting the conclusion that Dr. Isaiah's "surgical competence and clinical decision-making is below the standards of the hospital or other surgical staff"); Defs.' Ex. 18 (letter to Dr. Isaiah stating that the Board continued the suspension because of a variety of concerns including "excessive surgical time, excessive blood loss, lack of anatomical knowledge, lack of sufficient surgical skill, failure to provide full and accurate surgical reports, lack of proficiency with surgical instruments and techniques, inappropriate surgical judgments" and that those concerns led the Board to conclude

there was a "substantial likelihood of injury or detriment to the health or safety of patients"); Defs.' Ex. 21 (report of Hearing Panel that finds violations of the standard of care, discrepancies between records that are "inconsistent with quality patient care," and a variety of other concerns including "excessive blood loss. . . [and] indecision, occasional confusion").)

While two of defendants' review committees simply adopted and supported the recommendations of lower bodies, it can be inferred that these groups approved of the determination that Dr. Isaiah presented an impediment to quality health care. (*See* Defs.' Ex. 16 (report of Medical Executive Committee that notes the Committee accepted the recommendation of the Subcommittee, which clearly relied on concerns over health care quality); Defs.' Ex. 22 (report of Appellate Review Body that found the Hearing Panel's decision was supported by the evidence and fairly made).) Dr. Isaiah has produced no evidence showing that the findings of Dr. Raver, the Subcommittee, the Medical Executive Committee, the Board, the Hearing Panel, or the Appellate Review Body were unreasonable, and certainly has failed to rebut the presumption of immunity with respect to this prong.

Dr. Isaiah next argues that the various review committees could not have had a reasonable belief that they were acting in furtherance of quality health care because the members of those committees were not qualified to make a judgment about health care quality.[11] In particular, Dr. Isaiah asserts that an insufficient number of surgeons were members of the review committees. In *Imperial*, the plaintiff made a similar argument, contending that defendants were not entitled to immunity because it was open to question "whether defendants' actions were

[11] This argument also goes to the adequacy of the hearing provided by the defendants, *see infra*.

taken in the *reasonable belief* that they were in furtherance of quality health care . . . ."[12] 37 F.3d at 1028 (emphasis in original). The *Imperial* plaintiff "maintain[ed] that the other doctors reviewing his performance were not qualified to decide the medical issues because they did not practice in his field . . . ."[13] *Id.* at 1029.

The Fourth Circuit rejected this argument and found that while the reviewing doctors "were not in the same field as [plaintiff], it does not necessarily follow that the panel members could not form reasonable beliefs regarding the general quality of health care." *Id.* at 1030. The same reasoning controls here. Besides the fact that some surgeons did sit on the review committees (*see* Defs.' Ex. 22 at 2), there is no requirement that review committees be constituted of experts in the subject field. *See also infra* (discussing adequacy of the reviewing committees with respect to the adequacy of the hearing provided to plaintiff).

Dr. Isaiah makes a variety of arguments that must be dismissed simply because they are unsupported by the record. Although Dr. Isaiah nowhere contests the authenticity of the documents submitted by the defendants, he still he makes statements like the following:

> The hearing panel on or about November 22, 2005 issued a decision to continue plaintiff's suspension of privileges. The panel did not find that plaintiff's suspension was justified on the basis of the health, safety or protection of patients. Moreover, the hearing panel did not find that plaintiff had violated any standard of care in his care and treatment of patients.

(Am. Compl. ¶ 31; *see also* Pl.'s Mem. in Supp. of Mot. for Summ. J. at 14 ("[T]he hearing

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[12] The plaintiff in *Imperial* also argued that defendants did not have immunity because they failed to follow the Act's reporting requirements, but this exception to the Act's immunity provisions is not at issue in this suit. *Imperial*, 37 F.3d at 1028.

[13] The plaintiff in *Imperial* also argued, like the plaintiff here, that the members of the reviewing committee "were biased against him." *Imperial*, 37 F.3d at 1029. The Fourth Circuit dismissed that argument as well. *Id.* at 1028–30. I dismissed the conspiracy/bias argument *supra*.

panel [did not find] that patient safety was an issue much less that a violation of a standard of care had occurred.").)

This assertion is clearly contradicted by the record. In particular, the Hearing Panel found:

> That the physician failed to make a complete and accurate record of relevant events that occurred during the surgeries which were the focus of the hearing. Failure to document such events falls *below the accepted standard of care* of the hospital. . . .
> Excessive blood loss; fewer than average number of surgical procedures . . . ; longer than average times to perform surgeries; indecision, occasional confusion, obstinacy, and a reluctance to seek or accept suggestions or advise [sic] from the medical staff are evident in the record of those proceedings, and strongly suggest that the physician's present surgical skills and efficiency, temperament and personal traits *do not meet the generally accepted standard of care of the hospital.*

(Defs.' Ex. 21 at 1 (emphasis added).)

Clearly the Hearing Panel did find violations of the standard of care, and obviously had concerns going to the health and safety of patients.

Finally, Dr. Isaiah challenges the fact that the review committees and Dr. Raver relied on concerns about Dr. Isaiah's ethics and alleged obsessive-compulsive behaviors. This challenge fails for at least two reasons. First, I am in agreement with the Sixth Circuit that "'[q]uality health care is not limited to clinical competence, but includes matters of general behavior and ethical conduct." *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 469 (6th Cir. 2003). Second, defendants did not rely exclusively on ethical or behavioral conduct but rather repeatedly cited concerns about surgical competence and patient well-being, *see supra*.

Additionally, courts have found immunity in situations far more questionable than the instant one. For example, in *Lee v. Trinity Lutheran Hospital*, 408 F.3d 1064, 1071–72 (8th Cir. 2005), the Eighth Circuit upheld a finding of immunity even though the Executive Committee of

the hospital had *rejected* the recommendation of the Hearing Panel that the doctor's privileges be reinstated. The Eighth Circuit thus dismissed the idea that varying adjudications might indicate that the defendant was not acting in furtherance of health care. A similar conclusion was reached in *Gabaldoni*, in which the Fourth Circuit affirmed summary judgment in favor of the defendants even though the defendants' Credentials Committee, Medical Executive Committee, and the Hearing Committee "all recommended that [plaintiff] be reappointed" and the defendants' Board ignored those recommendations. 250 F.3d at 260–61. In the instant case, each review committee to consider the issue agreed that Dr. Isaiah's privileges should be suspended and revoked because of serious concerns about his surgical competence.

For the reasons outlined above, it is beyond dispute that defendants acted in the reasonable belief that their suspension and revocation of Dr. Isaiah's privileges were actions in the furtherance of quality health care. Moreover, Dr. Isaiah has certainly not provided sufficient evidence to rebut the presumption on this issue, as is necessary for him to avoid summary judgment on immunity grounds.

B. Reasonable Effort To Obtain The Facts

Dr. Isaiah next challenges whether defendants made a reasonable effort to obtain the facts in support of the suspension and revocation. His argument can best be addressed in two analyses: first, defendants' effort to obtain facts in advance of the precautionary suspension and, second, their effort to obtain facts in conjunction with the ultimate suspension and revocation.

Dr. Isaiah repeatedly objects to Dr. Raver's investigation of the facts in advance of the precautionary suspension. Many of Dr. Isaiah's claims are simply unsupported by any evidence, and contradicted by the record submitted by the defendants. For example, he claims that Dr.

Raver failed to "perform[] any investigation of the allegations and [did not] seek[] a review from the department of surgery" before issuing the precautionary suspension. (Am. Compl. ¶ 12.) He also claims that Dr. Raver "relied *solely* on the statement of an anesthesiologist" to justify the precautionary suspension. (Pl.'s Mem. in Supp. of Mot. for Summ. J. at 6 (emphasis added).) However, the only evidence presented on this issue supports a contrary view of the facts. In advance of any suspension, Dr. Raver spoke with Dr. Hodges (Defs.' Ex. 10) and Dr. Schroeder (a surgeon) (Defs.' Ex. 12), interviewed the operating room staff (Defs.' Ex. 10), and spoke with Dr. Isaiah himself (*id.*). All of this occurred in the two days between the disputed gallbladder surgery and the issuance of the precautionary suspension. Moreover, and directly contrary to Dr. Isaiah's claims, Dr. Raver obviously sought review from the Departments of Surgery because the Chairmen of those Departments both signed the precautionary suspension letter. (*See* Defs.' Ex. 13.)

Dr. Isaiah also contends that Dr. Raver reviewed no charts before issuing the precautionary suspension. Even accepting this contention as true, plaintiff's argument fails. Simply because Dr. Raver may not have looked at a chart does not mean that he could not have made a reasonable effort to obtain the facts and reach the reasonable conclusion that patient well-being was at risk. As made clear above, Dr. Raver took an extensive series of steps before issuing the precautionary suspension that made his investigation and Dr. Isaiah's consequent suspension entirely reasonable. These steps included, properly enough, discussions with other surgeons as well as operating room staff who were present at the disputed operation.

Looked at in totality, a reasonable effort to obtain facts was clearly made in advance of the precautionary suspension. Dr. Raver relied upon the first-hand observations of Dr. Hodges,

an experienced anaesthesiologist and respected member of the medical staff. Not content simply with Dr. Hodges' information, however, Dr. Raver also gathered information from another surgeon and the operating room staff. Moreover, Dr. Raver spoke to Dr. Isaiah himself before making any decisions. This effort is more than reasonable to justify a precautionary suspension.

Dr. Isaiah also disputes the fact investigation that precipitated his final suspension and revocation. This objection is meritless. As recounted above, each reviewing committee saw or heard evidence concerning the disputed gallbladder surgery as well as other surgeries. The Hearing Panel took testimony that included extensive evidence and briefing from both sides. The Board of Trustees was presented with a five-page evidentiary summary compiled by Dr. Raver (Defs.' Ex. 19) that presented facts from the year 2000 to the present, and went into significant detail concerning Dr. Isaiah's proctoring, history of debatable surgical competence, and questionable ethical behavior.

Although Dr. Isaiah objects to the sufficiency of the fact investigation, he also oddly objects to defendants' reliance on events other than the disputed gallbladder removal surgery. In this way, Dr. Isaiah complains both that defendants did not obtain enough facts and that defendants obtained too many facts. Such a position is untenable. Moreover, a hospital can properly take into account past problems and concerns when determining whether or not a doctor meets the standards of a hospital or the profession.

For these reasons, Dr. Isaiah has not rebutted the presumption of immunity with respect to this prong, and I hold that defendants made reasonable efforts to obtain the relevant facts before taking the disputed professional review actions.

C. Adequate Notice And Hearing Procedures

Dr. Isaiah next argues that defendants did not provide him with adequate notice and hearing procedures. As with the preceding prong, this analysis breaks down easily into the precautionary suspension and the ultimate revocation of Dr. Isaiah's privileges.

Specific statutory rules govern the adequacy of procedures provided for a precautionary suspension. In particular, the Health Care Quality Improvement Act allows for the "immediate suspension . . . of clinical privileges" when "the failure to take such an action may result in an imminent danger to the health of any individual." 42 U.S.C. § 11112(c)(2). Dr. Isaiah asserts that the precautionary suspension was improper because the decision was made without the reasonable belief that failure to suspend "may [have] result[ed] in an imminent danger to the health of any individual." (Pl.'s Mem. in Supp. of Mot. for Summ. J. at 13.) However, I am in agreement with the United States Court of Appeals for the Eighth Circuit, which has held that the statutory provision in question does not require "a currently identifiable patient whose health may be jeopardized." *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 917 (8th Cir. 1999) (rejecting argument that there was no imminent danger because plaintiff has no patients in hospital at time of suspension).

Rather, the statute requires only a reasonable belief that danger *may* result to *a* patient absent the precautionary suspension. *See Fobbs v. Holy Cross Health Sys. Corp.*, 29 F.3d 1439, 1443 (9th Cir. 1994) (finding that the Act "does not require imminent danger to exist before a summary restraint is imposed" but rather requires only "that the danger *may* result if the restraint is not imposed") (emphasis in original), *overruled on other grounds, Daviton v. Columbia/HCA Healthcare Corp.*, 241 F.3d 1131 (9th Cir. 2001); *see also Schindler v. Marshfield Clinic*, 2006 WL 2944703, at *13 (W.D. Wis. Oct. 12, 2006) ("Despite plaintiff's assertions to the contrary,

nothing in the Act requires imminent danger to exist before a summary restraint is imposed. It requires only that the danger *may* result if the restraint is not imposed.") (emphasis in original) (internal citations omitted).

Thus, it is not important that Dr. Isaiah's gallbladder patient made a full recovery or that Dr. Isaiah had no other patients in the hospital at the time of the precautionary suspension. Dr. Raver, the President of the Medical Staff, and the Chairmen of the Departments of Surgery had a reasonable belief, based on the investigation of the facts and the serious concerns expressed by other doctors and operating room personnel, that Dr. Isaiah's continued work may harm a patient. Such a belief is sufficient to support the issuance of a precautionary suspension.

Following this precautionary suspension, defendants provided Dr. Isaiah with more than sufficient notice and more than adequate hearing procedures. The fact that Dr. Isaiah was provided with notice is beyond dispute, and evident from the recitation of the facts above as well as the extensive record. On the question of a hearing's adequacy, the Third Circuit's opinion in *Brader* is instructive. 167 F.3d 832. There, the plaintiff alleged that the hearing was inadequate, but the Third Circuit disagreed, finding that the defendant had met the adequate hearing prong of the immunity inquiry. *Id.* at 841–43. In so finding, the Court emphasized that the defendant-hospital "gave [plaintiff] notice of each professional review action to be taken, informing him of his due process rights and the time in which he had to request a hearing."[14] *Id.* at 842. Obviously, defendants in the instant case gave notice, and informed Dr. Isaiah of his rights and

[14] Additionally, the Third Circuit was not troubled by the lack of notice provided to plaintiff before the summary suspension because 42 U.S.C. § 11112(c) "provides that the procedures of [42 U.S.C.] § 11112(a)(3) do not preclude 'an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.'" *Id.* (quoting 42 U.S.C. § 11112(c)).

the time in which he had to request a hearing; defendants also provided Dr. Isaiah with multiple and extensive hearings, as well as the discretionary right to appellate review.

A number of Dr. Isaiah's allegations concerning the notice and hearing procedures provided by defendants are simply erroneous. For example, Dr. Isaiah claims that: "On May 12, 2004, plaintiff received a notice from the respective hospitals of the proposed action to continue his suspension from the staff and to revoke his privileges. However, the notice was defective because it failed to state any grounds for the suspension that were authorized by the Bylaws." (Am. Compl. ¶ 25.) However, as discussed above, the May 12, 2004 letter to Dr. Isaiah stated a variety of grounds in support of the suspension and revocation, including that the Board had concluded that there was "a substantial likelihood of injury or detriment to the health or safety of patients." (Defs.' Ex. 18 at 1.) The Bylaws explicitly authorize precautionary suspensions "[w]henever a staff appointee's conduct shows the *substantial likelihood of immediate injury or is detrimental to the health or safety of any patient*, employee or other persons present in the Hospital . . . ." (Defs.' Ex. 13, Bylaws at 46 (emphasis added).)

Dr. Isaiah also objects to the composition of the review committees – in particular, that the committees had an insufficient number of surgeons. This argument can be quickly dismissed. To begin with, the record shows that a significant number of surgeons participated in the review process. (Defs.' Ex. 22 at 2 (noting that twelve surgeons, and fifteen additional physicians, were involved in the suspension and revocation decision).) Moreover, there is no requirement that a doctor be reviewed only by other medical doctors with the same speciality, training, or expertise. Indeed, one can imagine a different plaintiff with a differently composed review committee objecting to the fact that *too many* surgeons were on the panel with

consequently too strict standards. For these reasons, I find that Dr. Isaiah has failed to rebut the presumption that defendants provided him with adequate notice and hearing procedures.

D. Reasonable Belief That The Action Was Warranted

The final prong of the immunity analysis requires that this Court determine whether defendants acted with a "reasonable belief that the [professional review] action was warranted . . . ." 42 U.S.C. § 11112(a). This question is very similar to the first one discussed above, examining whether or not defendants had a reasonable belief that their actions were taken in furtherance of quality health care. *See, e.g.*, *Brader*, 167 F.3d at 843 ("Our analysis under § 11112(a)(4) closely tracks our analysis under § 11112(a)(1)."). As I held *supra*, defendants had a reasonable belief that their actions were in furtherance of health care. I now hold that defendants had a reasonable belief that their actions were warranted in light of the facts.

This is not to say that defendants' reasonable belief that Dr. Isaiah presented a threat to patient safety necessarily was correct. Rather, "[t]he 'reasonable belief' standard embodies the discretion that health care professionals have traditionally exercised in determining whether or not their peers meet a requisite level of professional competence." *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 212 (4th Cir. 2002) (affirming constitutionality of the Health Care Quality Improvement Act and its immunity provisions). Defendants acted reasonably, and did not abuse the discretion that Congress has granted to them. Accordingly, I hold that plaintiff has failed to rebut the presumption of immunity that the Health Care Quality Improvement Act accords to these defendants.[15]

[15] The cases relied upon by the plaintiff do not alter this result. For example, in *Brown v. Presbyterian Healthcare Services*, 101 F.3d 1324, 1333–34 (10th Cir. 1996), the Tenth Circuit found that the plaintiff had put forth sufficient evidence to show that defendant's actions were not reasonable under the Health Care Quality Improvement Act. The doctor in *Brown*, however, had been disciplined in light of a violation of an agreement that

III. Immunity Under Maryland Law

I similarly conclude that defendants are entitled to immunity under Maryland law. Immunity under Maryland law is distinct from immunity under the Health Care Quality Improvement Act. *See, e.g., Imperial.*, 37 F.3d at 1031–32 (noting that Maryland immunity is "broader in scope than the immunity granted by the Health Care Quality Improvement Act"). In particular, the relevant "Maryland statute requires that a member of a review committee act in good faith, while the [Health Care Quality Improvement Act] employs objective standards of reasonableness . . . ."[16] *Goodwich*, 680 A.2d at 1082. Thus, "[t]he State law . . . may, *in some circumstance*s, provide additional immunity or protection to medical review bodies." *Id.* (quoting *Goodwich v. Sinai Hosp. of Balt.*, 653 A.2d 541, 548 (Md. Ct. Spec. App. 1995)) (emphasis in original); *Bender v. Suburban Hosp., Inc.*, 758 A.2d 1090, 1104 (Md. Ct. Spec. App. 2000) ("To be sure, the immunity provided by Maryland's statute might in some circumstances exceed that provided by the [Act], because Maryland requires that reviewers act under a good faith standard, rather than a standard of objective reasonableness.").

The Maryland Court of Special Appeals has explained the interplay between the federal

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had been reached with the defendants, and not, as here, due to a perceived threat to patient well-being. *Id.* Similarly unhelpful is the Third Circuit's opinion in *Brader v. Alleghany General Hospital*, 64 F.3d 869 (3d Cir. 1995) (*Brader I*). There, the court simply found that plaintiff's *pleadings* were sufficient to survive a motion to dismiss on immunity grounds. *Id.* at 879–80. Here, as both plaintiff and defendants acknowledge by their filing of summary judgment motions, a great deal of evidence has been presented and this Court can thus look beyond the pleadings. Moreover, after the Third Circuit reversed and remanded in *Brader*, the district court granted defendants' summary judgment motion and that decision was affirmed by the Third Circuit on immunity grounds. *Brader II*, 167 F.3d at 843 (discussed *supra*).

[16] Dr. Isaiah states, citing *Goodwich*, that "the Maryland Court of Appeals [has] held that the [Maryland] standard for determining whether the Hospital was immune" is "based on a standard of 'objective reasonableness.'" (Pl.'s Reply at 17.) This is precisely the opposite of what *Goodwich* says. *See Goodwich*, 680 A.2d at 1082 ("Our decision is based upon [the Health Care Quality Improvement Act] immunity provisions, so we do not reach the applicability of the Maryland statutory provisions. We, therefore, pause only to voice our agreement with the Court of Special Appeals that because the Maryland statute requires that a member of a review committee act in good faith, *while the [federal act] employs objective standards of reasonableness . . . .*") (emphasis added).

immunity provisions and the state immunity statutes as follows:

> In practice, the State and Federal statutes may coexist. If a medical review body's actions are performed with malice, but nonetheless are deemed to be objectively reasonable, the body will be immune under Federal law; the lack of State immunity because of the absence of good faith would be immaterial, for the Federal law would govern. If, however, the review actions are not reasonable, thereby providing no Federal immunity, the court would then have to consider whether the actions were nonetheless taken in good faith, for, if they were, State immunity might exist.

Id.

After reviewing all of the evidence and construing all of the facts in the light most favorable to the plaintiff, I find not a scintilla of evidence that defendants acted in bad faith. Dr. Isaiah's continued baseless references to conspiracies and secret files notwithstanding, all of the evidence presented indicates that defendants were alerted to a problem, undertook an examination of that problem and past problems, and acted reasonably in light of those issues.

CONCLUSION

There is no doubt that Dr. Isaiah introduced evidence at his hearing that supported the conclusion that he did nothing wrong during the disputed gallbladder removal surgery. But there is also no question that contrary evidence, supporting the view that Dr. Isaiah acted in an incompetent manner, was also introduced at the hearing. Most importantly, defendants introduced a plethora of evidence that gave rise to legitimate, reasonable concerns about Dr. Isaiah's ability to perform operations in a safe and ethical manner. The question before this Court is not whether the evidence presented to the Hearing Panel could support a finding that Dr. Isaiah acted properly. Rather, the question is whether defendants acted *reasonably* in concluding that Dr. Isaiah did not act properly. Looking at the evidence presented, no reasonable jury could conclude that defendants acted unreasonably.

It is important to note that the pending motion is not a motion to dismiss. Dr. Isaiah's complaint may well have survived such a motion because he may well have pled facts sufficient to rebut the presumption of immunity. However, the instant motion is one for summary judgment, and the extensive record presented supports immunity in full. At this stage of the litigation, plaintiff cannot rely upon the unsupported allegations in his complaint. Defendants' conclusions about Dr. Isaiah's abilities may or may not be accurate, but the Health Care Quality Improvement Act "does not require that the professional review result in an actual improvement of the quality of health care." *Imperial*, 37 F.3d at 1030.

"In this case, a physician who had been disciplined by his hospital sought to have a court revisit that adverse medical and administrative judgment. This is precisely the type of case that Congress intended to foreclose in the passing the [Health Care Quality Improvement Act]." *Brader*, 167 F.3d at 843. It is not this Court's proper role to engage in a wholesale reevaluation of the medical evidence and the accuracy of defendants' conclusions. *See, e.g.*, *Bender*, 758 A.2d at 1109 ("It is not the function of this Court under the [Health Care Quality Improvement Act] to reweigh the evidence or substitute our judgment for that of [defendant's] peer review bodies."). Congress has instructed that if a hospital acts in a reasonable manner, that hospital will be immune from civil damages suits like the instant one. In light of this dictate, plaintiff's motion for summary judgment will be denied, defendants' motion for summary judgment will be granted, and plaintiff's case will be dismissed.[17]

A separate order effecting the rulings made in this Memorandum is being entered

[17] Because I find that defendants are entitled to immunity, I need not reach the question of whether plaintiff has made out a *prima facie* claim for tortious inference with prospective advantage, defamation, and false light invasion of privacy.

herewith.

July 25, 2008

/s/
J. Frederick Motz
United States District Judge

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

ISAAC ISAIAH, M.D.	*	
Plaintiff,	*	
	*	
v.	*	Civil No. JFM 07–2197

	*
WHMS BRADDOCK HOSPITAL CORP.	*
& THE MEMORIAL HOSPITAL AND	*
MEDICAL CENTER OF CUMBERLAND	*
INC.	*
Defendants.	*
	*

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ORDER

For the reasons stated in the accompanying memorandum, it is, this 25th day of July, 2008

ORDERED

1. Plaintiff's motion for summary judgment is denied;

2. Defendants' motions for summary judgment are granted;

3. Judgment will be entered for defendants, and the case closed.

/s/
J. Frederick Motz
United States District Judge